CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

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900 CHAPTER OVERVIEW

The standards and requirements included in this Chapter are applicable to AHCCCS Acute Care and ALTCS Contractors, the Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD), the ADES Comprehensive Medical and Dental Plan (ADES/CMDP), the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), and the ADHS Children's Rehabilitation Services (ADHS/CRS). If requirements of this Chapter conflict with specific contract language, the contract will take precedence. For purposes of this Chapter, the above listed organizations and agencies will be referred to as "Contractors."

The Chapter provides information needed by Contractors to:

1. Promote improvement in the quality of care provided to enrolled members through established processes including:

    a. Monitoring and evaluating the Contractor's service delivery system and provider network, as well as its own processes for quality management and performance improvement

    b. Implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members, and

    c. Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.

2. Comply with Federal, State and AHCCCS requirements

3. Ensure coordination with State registries

4. Ensure Contractor executive and management staff participation in the quality management and performance improvement processes

5. Ensure that the development and implementation of quality management and performance improvement activities include contracted provider participation and information provided by members, their families and guardians, and

6. Identify the best practices for performance and quality improvement.

• DEFINITIONS

The words and phrases in this Chapter have the following meanings, unless the context explicitly requires another meaning.

1. **Assess or Evaluate** means the process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

2. **Completion/Implementation Timeframe** means the date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the Contractor.

3. **CQM** means the Clinical Quality Management Unit of the AHCCCS Division of Health Care Management that evaluates Contractor Quality Management/Performance Improvement (QM/PI) programs, monitors compliance with required standards, Contractor corrective action plans and Performance Improvement Projects (PIPs), and provides technical assistance for improvement.

4. **Corrective Action Plan (CAP)** means a written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance QM/PI activities and the outcomes of the activities, or to resolve a deficiency.

5. **Demonstrable Improvement** means the projected percentage of performance improvement submitted as a part of the Contractor's PIP proposal and approved by AHCCCS for the project outcome.

6. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights. Grievances do not include "action(s)" as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

7. **Measurable** applies to a Contractor objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.

8. **Methodology** means the planned process, steps, activities or actions taken by a Contractor to achieve a goal or objective, or to progress toward a positive outcome.

9. **Monitoring** means the process of observing, evaluating, analyzing and conducting follow-up activities.

10. **Objective** means a measurable step, generally in a series of progressive steps, to achieve a goal.

11. **Performance Improvement Project (PIP)** means a planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

• REFERENCES

1. Title 42 of the Code of Federal Regulations (42 CFR) 431.300 *et seq* (Safeguarding Information on Applicants and Recipients)

2. 42 CFR 438.200 *et seq* (Quality Assessment and Performance Improvement Including Health Information Systems)

3. 45 CFR Part 164 (HIPAA Privacy Requirements)

4. Arizona Revised Statutes (A.R.S.) §§ 36-2903, 36-2932, 36-2986 (Duties of the Administration)

5. A.R.S. § 36-2917 (Review Committees)

6. Title 9 of the Arizona Administrative Code, Chapter 22 (9 A.A.C. 22), Article 5 (General Provisions and Standards)

7. 9 A.A.C. 22, Article 12 (General Provisions and Standards for Service Providers)

8. 9 A.A.C. 28, Article 5 (General Provisions and Standards)

9. 9 A.A.C. 28, Article 11 (General Provisions and Standards for Service Providers)

10. 9 A.A.C. 31, Article 5 (General Provisions and Standards)

11. 9 A.A.C. 31, Article 12 (General Provisions and Standards for Service Providers)

12. 9 A.A.C. 34 (Grievance System), and

13. AHCCCS Contracts.

910 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM ADMINISTRATIVE REQUIREMENTS

A. QM/PI PLAN

1. Each Contractor must develop a written QM/PI Plan that addresses the Contractor's proposed methodology to meet or exceed the standards and requirements of this Chapter. The QM/PI Plan, and any subsequent modifications, must be submitted to AHCCCS/Division Of Health Care Management (DHCM)/CQM for review and approval prior to implementation. At a minimum, the QM/PI Plan must describe, in detail, the following components of the Contractor's QM/PI Program and how Program activities will improve the quality of care and service delivery for enrolled members. QM/PI Plan components must include:

    a. A description of the Contractor's administrative structure for oversight of its QM/PI Program as required by Policy 910.C of this Chapter, including the role and responsibilities of:

        (1) The governing or policy-making body

        (2) The QM/PI Committee

        (3) The Contractor's Executive Management, and

        (4) QM/PI Program staff.

    b. An organizational chart that delineates the reporting channels for QM/PI activities and the relationship to the Contractor Medical Director and Executive Management

    c. Documentation that the governing or policy-making body has reviewed and approved the Plan

    d. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out QM/PI program functions and meet Contractor qualifications required by Policy 910.C

e. The Contractor's specific QM/PI goals and measurable objectives as required by Policy 920.A of this Chapter

f. A work plan that addresses all requirements of Policy 920.A of this Chapter, the AHCCCS-suggested guidelines, and supports the Contractor's QM/PI goals and objectives

g. The Contractor's method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with Policy 920.B of this Chapter

h. A description of how delegated activities are integrated into the overall QM/PI Program and the methodologies for oversight and accountability of all delegated functions, as required by Policy 910.C.

i. A description of how member rights and responsibilities are defined, implemented and monitored to meet requirements of Policy 930 of this Chapter

j. Documentation that the Contractor has implemented policies and procedures in compliance with Policy 940 of this Chapter to ensure that medical records and communications of clinical information for each member reflect all aspects of patient care, including ancillary services

k. A description of the Contractor's temporary/provisional credentialing, initial credentialing and re-credentialing processes for providers contracted with the Contractor, as required by Policy 950 of this Chapter

l. A description of the Contractor's process for grievance resolution, tracking and trending that meets standards set in Policy 960 of this Chapter and 42 CFR 438.242 *et seq*

m. Documentation of the Contractor's planned activities to meet or exceed AHCCCS-mandated performance measures and performance improvement projects as specified in contract and required by Policies 970 and 980 of this Chapter, and

n. Indication or documentation of input from contracted or affiliated providers and members.

B. QM/PI EVALUATION

An evaluation of the previous year's activities must also be submitted as part of the QM/PI Plan, after being reviewed and approved by the Contractor's governing or policy making body, as required by Policy 910.C.

NOTE: See Policy 990 of this Chapter, and Chapter 400, Exhibit 400-1, for reporting requirements and timelines.

For submission to AHCCCS/DHCM/CQM, the following may be combined or written separately as long as required components are addressed and are easily located within the document(s) submitted:

- QM/PI Plan and workplan
- QM/PI Evaluation
- Maternal and Child Health Plan, as set forth in Exhibit 400-1
- PIP Proposal, and
- PIP Interim Report(s).

C. QM/PI PROGRAM ADMINISTRATIVE OVERSIGHT

1. The Contractor's QM/PI Program must be administered through a clear and appropriate administrative structure. The governing or policy-making body must oversee and be accountable for the QM/PI program. The Contractor must:

    a. Ensure ongoing communication and collaboration between the QM/PI Program and the other functional areas of the organization (e.g., health services management, member services and case management), and

b. Formally evaluate and document the effectiveness of its QM/PI Program strategy and activities, at least annually. The annual evaluation report must document the following:

(1) A summary of all QM/PI activities performed throughout the year with:

(a) Title/name of each activity

(b) Goal and/or objective(s) related to each activity

(c) Contractor departments or units and staff positions involved in the QM/PI activities

(d) Description of the communication and feedback based on QM/PI data and activities

(e) Statement describing if the goals/objectives were met completely, partially or not at all, and

(f) Actions to be taken for improvement (CAP).

(2) Trends identified through QM/PI activities and resulting actions taken for improvement

(3) Rationale for changes in the scope of the QM/PI Program and Plan

(4) Review, evaluation and approval by the QM/PI Committee of any changes to the QM/PI Plan, and

(5) Necessary follow-up with targeted timelines for revisions made to the QM/PI Plan.

2. The Contractor must maintain records that document QM and PI activities, and make the data available to AHCCCS/DHCM/CQM upon request. The required documentation must include, but is not limited to:

a. Policies and procedures

b. Studies and PIPs

c. Reports

d. Protocols

e. Standards

f. Worksheets

g. Meeting minutes

h. CAPs, and

i. Other information and data deemed appropriate to support changes made to the scope of the QM/PI Plan and Program.

3. The Contractor must have an identifiable, structured QM/PI Committee that is responsible for QM/PI functions and responsibilities.

   a. At a minimum, the membership must include:

      (1) The Medical Director as the chairperson of the Committee (the Medical Director may designate the Associate Medical Director as his/her designee only when the Medical Director is unable to attend the meeting)

      (2) The QM/PI Manager

      (3) Representation from the functional areas within the organization, and

      (4) Representation of contracted or affiliated providers.

   b. The Medical Director, as chairperson for the QM/PI Committee, or his/her designee, is responsible for implementation of the QM/PI Plan, and must have substantial involvement in the assessment and improvement of QM/PI activities.

c. The QM/PI Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (i.e., a signed statement on file or QM/PI Committee sign-in sheets with requirements noted).

d. The frequency of committee meetings must be sufficient to demonstrate that the QM/PI Committee monitors all findings and required actions. At a minimum, the Committee should meet on a quarterly basis.

e. The QM/PI Committee must review the QM/PI Program objectives, policies and procedures at least annually and modify or update them as necessary.

(1) The QM/PI Committee must develop procedures for QM/PI responsibilities and clearly document the processes for each QM/PI function/activity.

(2) The QM/PI Committee must develop and implement procedures to ensure that Contractor staff and providers are informed of the most current QM/PI requirements, policies and procedures.

(3) The QM/PI Committee must develop and implement procedures to ensure that providers are informed of information related to their performance (i.e., results of studies, AHCCCS Performance Measures, profiling data, etc.)

(4) The QM/PI policies and procedures, and any subsequent modifications to them, must be available upon request for review by AHCCCS/DHCM/CQM or BH.

4. The Contractor's peer review process must be clearly defined with specific policies and procedures that address:

a. How the review process is used to analyze and address clinical issues

b. How providers are made aware of the peer review process

c. How providers are made aware of the peer review grievance procedure, and

d. Whether peer review activities are carried out in a specific peer review committee meeting or in executive session. At least one provider of the same or similar specialty under review must be available for the peer review process.

5. The QM/PI Program must be staffed with sufficient appropriately qualified personnel to carry out the functions and responsibilities specified in this Chapter in a timely and competent manner.

    a. Staff qualifications for education, experience and training must be developed for each QM/PI position.

    b. A current organizational chart must be maintained to show reporting channels and responsibilities for the QM/PI Program.

6. The Contractor must oversee and maintain accountability for all functions or responsibilities described in this Chapter that are delegated to other entities. Documentation must be kept on file, for AHCCCS review, that shows the following requirements have been met for all delegated functions:

    a. A written agreement must be executed that specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance.

    b. The Contractor must evaluate the entity's ability to perform the delegated activities prior to delegation.

    c. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed by the Contractor at least annually.

    d. The following documentation must be kept on file and available for AHCCCS review:

        (1) Evaluation reports, and

        (2) CAPs, as necessary, to ensure quality for all delegated activities.

7. Each Contractor must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/PI Program. Data elements must include:

    a. Member demographics

b. Provider characteristics

c. Services provided to members, and

d. Other information necessary to guide the selection of, and meet the data collection requirements for PIPs and QM/PI oversight.

8. The Contractor must have written policies and procedures to ensure that:

a. Information/data received from providers is accurate, timely and complete

b. Reported data is reviewed for accuracy, completeness, logic and consistency, and that the review and evaluation processes used are clearly documented

c. All member and provider information protected by Federal and State law is kept confidential

d. Contractor staff and providers are kept informed of at least the following:

(1) QM/PI requirements, activities, updates or revisions

(2) Study and PIP results

(3) Performance measures

(4) Utilization data, and

(5) Profiling results.

920 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM SCOPE

A. QM/PI PROGRAM COMPONENTS

The QM/PI Program must:

1. Develop a detailed, written set of specific measurable objectives that demonstrate how the Contractor's QM/PI Program meets established goals and complies with all components of this Chapter.

2. Develop and implement a work plan with timelines to support the objectives including:

   a. A description of all planned activities/tasks for both clinical care and other covered services

   b. Targeted implementation and completion dates for QM measurable objectives, activities and PI projects

   c. Methodologies to accomplish goals and objectives

   d. Staff positions responsible and accountable for meeting established goals and objectives, and

   e. Detailed policies and procedures to address all components and requirements of this Chapter.

3. Develop and implement a process to ensure that a "best-effort" attempt has been made to conduct an initial health assessment of each member's health care needs, including follow up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment.

   a. Refer to Chapter 1600 to obtain time frames in which case managers must have an initial contact with newly enrolled ALTCS members.

b. Refer to contract to obtain timeframes in which ADHS/DBHS-affiliated contractors/providers must have first contact with members referred to Regional Behavioral Health Agencies (RBHAs) and Tribal Regional Behavioral Health Agencies (TRBHAs).

4. Ensure continuity of care and integration of services through:

   a. Policies and procedures to allow each member to select, or the Contractor to assign, a primary care provider (PCP) (or a clinician for an ADHS/DBHS member) who is formally designated as having primary responsibility for coordinating the member's overall health care

      NOTE: For purposes of this policy, a PCP includes a clinical liaison for an ADHS/DBHS member.

   b. Policies and procedures that specify under what circumstance services are coordinated by the Contractor, the methods for coordination and specific documentation of these processes

   c. Programs for care coordination that include coordination of covered services with community and social services, generally available through contracting or non-contracting providers, in the Contractor service area

   d. Policies and procedures that specify services coordinated by the Contractor's Disease Management Unit, and

   e. Policies and procedures for timely and confidential communication of clinical information among providers, as specified in Policy 940 of this Chapter.

5. Implement measures to ensure that members:

   a. Are informed of specific health care needs that require follow-up

   b. Receive, as appropriate, training in self-care and other measures they may take to promote their own health, and

c. Are informed of their responsibility to comply with prescribed treatments or regimens.

6. Develop policies, and implement procedures, for members with special health care needs, as defined in contract, including:

   a. Identifying members with special health care needs, including those who would benefit from disease management

   b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member identified as having special health care need(s) or condition(s)

   c. Identifying medical procedures (and/or behavioral health services, as applicable) to address and/or monitor the need(s) or condition(s)

   d. Ensuring adequate care coordination among providers, including other Contractors, as necessary, and

   e. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits).

B. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES

1. The QM/PI Program scope of monitoring and evaluation must be comprehensive. It must incorporate the activities used by the Contractor, and demonstrate how these activities will improve the quality of services and the continuum of care in all services sites. These activities must be clearly documented in policies and procedures.

2. Information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues should be used in developing PI projects. Selection of specific monitoring and evaluation activities should be appropriate to each specific service or site.

3. The services and service sites to be monitored by ADHS/DBHS or its contractors must include, but are not limited to, the following:

Services	Service Sites
• Behavioral Management (behavioral health personal assistance, family support, peer support) • Case Management Services • Emergency/Crisis Behavioral Health Services • Emergency Transportation • Evaluation and Screening (initial and ongoing assessment) • Group Therapy and Counseling • Individual Therapy and Counseling • Family Therapy and Counseling • Inpatient Hospital • Inpatient Psychiatric Facilities (resident treatment centers and sub-acute facilities) • Institutions for Mental Diseases • Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis • Non-emergency Transportation • Nursing • Opioid Agonist Treatment • Partial Care (supervised day program, therapeutic day program and medical day program) • Psychosocial Rehabilitation (living skills training, health promotion and supported employment) • Psychotropic Medication • Psychotropic Medication Adjustment and Monitoring • Respite Care • Therapeutic Foster Care Services	• Behavioral Health Outpatient Clinics • Hospital (if it includes a distinct behavioral health or detoxification unit) • Level I Behavioral Health Facility • Level II Behavioral Health Facility • Level III Behavioral Health Facility • Psychiatric Hospital • Therapeutic Foster Care Home (Adults and Children) • Community Service Agency • Rural Substance Abuse Transitional Center

4. The services and service sites to be monitored by Acute Care Contractors and CRS must include, but are not limited to, the following:

Services	**Service Sites**
• Ancillary • Dental • Emergency • EPSDT • Family Planning • Obstetric • Pharmacy • Prevention and Wellness • Primary Care • Specialty Care • Other (e.g. DME/Medical Supplies, Home Health Services, Therapies, Transportation, etc.)	• Ambulatory Facilities • Hospitals • Nursing Facilities

5. The services and service sites to be monitored by ALTCS Contractors must include, but are not limited to, the following:

Services	Service Sites
• Adult Day Health Care • Ancillary • Attendant Care • Behavioral Health • Dental • DME/Medical Supplies • Emergency • Emergency Alert • Environmental Modifications • EPSDT • Family Planning • Habilitation Services (as applicable) • Home Delivered Meals • Home Health Services • Homemaker • Hospice • Medical/Acute Care • Obstetric • Personal Care • Prevention and Wellness • Respiratory Therapy • Respite Care • Specialty Care • Therapies (OT, PT, Speech) • Transportation	• Assisted Living Centers • Assisted Living Homes • Ambulatory Facilities • Behavioral Health Facilities • DD Group Homes • Foster Care Homes • Hospice • Hospitals • Institution for Mental Diseases • Intermediate Care Facilities for the Mentally Retarded • Nursing Facilities • Own Home • Residential Treatment Centers • Traumatic Brain Injury Facilities

6. Contractors must implement policies and procedures for initial and subsequent monitoring visits to the offices of primary care providers (PCPs) and high volume specialists. Visits must be conducted at least every three years to:

   a. Review and document findings regarding medical record keeping practices, and

   b. Assure compliance with Contractor's standards.

C. IMPLEMENTATION OF ACTIONS TO IMPROVE CARE

1. Contractors must develop work plans for taking appropriate actions to improve care if problems are identified. The work plans should address the following:

   a. Specified type(s) of problem(s) that requires corrective action

   b. Person(s), or body (e.g., Board) responsible for making the final determinations regarding quality issues

   c. Type(s) of member/provider action(s) to be taken including:

      (1) Education/training/technical assistance

      (2) Follow-up monitoring and evaluation of improvement

      (3) Changes in processes, structures, forms

      (4) Informal counseling, and/or

      (5) Termination of affiliation with provider.

   d. Assessment of the effectiveness of actions taken

   e. Method(s) for internal dissemination of findings and resulting work plans to appropriate staff and/or network providers, and

f. Method(s) for dissemination of pertinent information to AHCCCS Administration and/or regulatory boards and agencies (i.e., Arizona Department of Health Services, Arizona Medical Board, Arizona State Board of Nursing, etc.)

2. Contractors must maintain documentation that confirms the implementation of corrective actions.

930 MEMBER RIGHTS AND RESPONSIBILITIES

1. Contractors must have written policies and procedures that address, at a minimum, the following member rights and how these rights are disseminated to members and providers. Each member will:

   a. Be treated with respect and with recognition of the member's dignity and need for privacy

      (1) The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.

      (2) The Contractor must implement procedures to ensure the confidentiality of health and medical records and of other member information. (Refer to the Medical Records Requirements included in Policy 940 of this Chapter.)

   b. Not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment

   c. Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in different formats, as appropriate.

   d. Have the opportunity to choose a primary care provider (PCP), within the limits of the provider network, and choose other providers as needed from among those affiliated with the network. This also includes the right to refuse care from specified providers.

   e. Participate in decision-making regarding their health care, and/or have a representative facilitate care or treatment decisions, including the right to refuse treatment, when the member is unable to do so

   f. Have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

g. Be provided with information about formulating advance directives. (The Contractor must provide for involvement by the member or their representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment within the requirements of Federal and State law with respect to advance directives.)

h. Receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:

(1) Provisions for after-hour and emergency health care services. Information provided must notify members that they have the right to access emergency health care services from contracting or non-contracting providers without prior authorization, consistent with the member's determination of the need for such services as a prudent layperson.

(2) Information about available treatment options (including the option of no treatment) or alternative courses of care

(3) Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance abuse services, or referrals for specialty services not furnished by the member's PCP

(4) Procedures for obtaining services outside the geographic service area of the Contractor

(5) Provisions for obtaining AHCCCS covered services that are not offered or available through the Contractor, and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider, and

(6) A description of how the organization evaluates new technology for inclusion as a covered benefit.

i. Be provided with information regarding grievances, appeals and requests for hearing.

j. Have access to review his/her medical records in accordance with applicable Federal and State laws, and/or:

k. Have the right to request and receive a copy of his/her medical records as specified in Title 45 of the Code of Federal Regulations (CFR) 164.524:

(1) The member's right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:

(a) Psychotherapy notes

(b) Compiled for, or in reasonable anticipation of, a civil, criminal or administrative action, or

(c) Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2).

(2) An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 CFR Part 164 (above) if:

(a) The information meets the criteria stated in section k (1) above

(b) The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 CFR 164.501

(c) The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research

(d) The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services

(e) The denial of access meets the requirements of the Privacy Act, 5 United States Code (5 U.S.C.) 552a, or

(f) The information was obtained from someone other than a health care provider under the protection of confidentiality and access would be reasonably likely to reveal the source of the information.

(3) Except as provided in k (1 and 2) above, an individual must be informed of the right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:

(a) A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person, or

(b) The protected health information makes reference to another person and access would reasonably be likely to cause substantial harm to the member or another person.

(4) The Contractor must respond within 30 days to the member's request for a copy of the records. The response may be the copy of the record or, if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in accordance with 45 CFR Part 164.

l. Have the right to amend or correct his/her medical records as specified in 45 CFR 164.526:

(1) The Contractor may require the request be made in writing.

(2) If the Contractor agrees to amend information in the member's medical record, in whole or in part. At a minimum, the Contractor must:

(a) At a minimum, identify the information in the member's record that is affected, and attach or link to the amended information

(b) Inform the member, in a timely manner, of the amendment

(c) Obtain the member's agreement to allow the Contractor to notify relevant persons with whom the amendment needs to be shared, and

(d) The Contractor must make reasonable efforts to inform and provide the amendment, within a reasonable time, to:

(i) Persons identified by the member as having received protected health information and who need the amendment, and

(ii) Persons, including business associates, that are known to the Contractor as having member information affected by the amendment and who have relied on or may in the future rely on the original information to the detriment of the member.

(3) A Contractor may deny the request for amendment or correction if the information:

(a) Would not be available for review (as stated in section l (1) or (2) above)

(b) Was not created by the Contractor, or one of its providers, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment

(c) Is not a part of the member's medical record, or

(d) Is already accurate and complete.

(4) If the request is denied, in whole or in part, the Contractor must provide the member with a written denial within 60 days that includes:

(a) The basis for the denial

(b) The member's right to submit a written statement disagreeing with the denial, and how to file the statement

(c) A statement that, if the member does not submit a statement of disagreement, the member may request the Contractor provide the member's request for amendment and the denial with any future disclosures of the protected health information that is related to the amendment, and

(d) A description of how the member may seek review of the denial in accordance with 45 CFR Part 164.

2. Contractors must ensure each member is free to exercise his or her rights and that the exercising of those rights will not adversely affect the treatment of the member by the Contractor or its providers.

3. Each Contractor must have a written policy addressing member responsibilities. Member responsibilities include:

a. Providing, to the extent possible, information needed by professional staff in caring for the member

b. Following instructions and guidelines given by those providing health care

c. Knowing the name of the assigned PCP

d. Scheduling appointments during office hours whenever possible instead of using urgent care facilities and/or emergency rooms

e. Arriving for appointments on time

f. Notifying the provider in advance when it is not possible to keep an appointment, and

g. Bringing immunization records to every appointment for children 18 years of age or younger.

4. Contractors must refer to the AHCCCS contract for requirements concerning member handbooks and notification of members regarding their rights and responsibilities.

5. Contractors must refer to Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34) and the AHCCCS contract for information regarding requirements for the grievance system for members and providers.

940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

1. Contractors must implement appropriate policies and procedures to ensure that the organization and its providers have information required for:

   a. Effective and continuous patient care through accurate medical record documentation of each member's health status, changes in health status, health care needs, and health care services provided

   b. Quality review, and

   c. The conduct of an ongoing program to monitor compliance with those policies and procedures.

2. Each Contractor must implement policies and procedures that address medical records and the methodologies to be used by the organization to:

   a. Ensure that contracted primary care providers (PCPs) maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures and/or receive medical/behavioral health records from other providers who have seen the enrolled member, and confirm that the record is kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the PCP must maintain a comprehensive record that incorporates at least the following components:

      (1) Member identification information on each page of the medical record (i.e., name or AHCCCS identification number)

      (2) Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative

(3) Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)

(4) Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received

(5) Immunization records (required for children; recommended for adult members if available)

(6) Dental history if available, and current dental needs and/or services

(7) Current problem list

(8) Current medications

(9) Documentation, initialed by the member's PCP to signify review of:

(a) Diagnostic information including:

i. Laboratory tests and screenings

ii. Radiology reports

iii. Physical examination notes, and

iv. Other pertinent data.

(b) Reports from referrals, consultations and specialists

(c) Emergency/urgent care reports

(d) Hospital discharge summaries, and

(e) Behavioral health referrals and services provided, if applicable.

(10) Documentation as to whether or not an adult member has completed advance directives

(11) Documentation related to requests for release of information and subsequent release, and

(12) Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.

b. Ensure that obstetric providers complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologists [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.

c. Confirm that each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, etc.) maintains a record of the services provided to a member, including:

(1) Physician or provider orders for the service

(2) Applicable diagnostic or evaluation documentation

(3) A plan of treatment

(4) Periodic summary of the member's progress toward treatment goals

(5) The date and description of service modalities provided, and

(6) Signature/initials of the provider for each service.

d. Take into consideration professional and community standards and accepted and recognized practice guidelines

e. Implement a process to assess and improve the content, legibility, organization, and completeness of member health records, and

f. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants are allowed to provide services.

3. Medical records may be documented on paper or in an electronic format.

   a. If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date for each entry.

   b. If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made; correction fluid or tape are not allowed.

   c. If kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.

   d. If revisions to information take place, a system must be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information must be maintained.

4. Each Contractor must have written policies and procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and must conduct reviews to verify that:

   a. A provider making a referral transmits necessary information to the provider receiving the referral

   b. A provider furnishing a referral service reports appropriate information to the referring provider

   c. Providers request information from other treating providers as necessary to provide appropriate and timely care

d. Information about services provided to a member by a non-network provider (i.e., emergency services, etc.) is transmitted to the member's PCP

e. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP, and

f. Member information is shared, when a member subsequently enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care.

5. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must implement a process to ensure that unauthorized individuals cannot gain access to, or alter, member records.

6. Original and/or copies of medical records must be released only in accordance with Federal or State laws and AHCCCS policy and contracts. Contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 *et seq.*

Refer to Chapter 600, Policy 650 and AHCCCS contract for a complete discussion on advance directives for adult members.

950 CREDENTIALING AND RE-CREDENTIALING PROCESSES

Overview

This policy covers credentialing, temporary/provisional credentialing and re-credentialing policies for both individual and organizational providers.

Credentialing Individual Providers

The Contractor must have a written system in place for credentialing and re-credentialing providers included in their contracted provider network.

1. Credentialing and re-credentialing must be conducted and documented for at least the following contracted health care professionals:

    a. Physicians (MDs, DOs and DPMs)

    b. Nurse practitioners, physician assistants or certified nurse midwives providing primary care services, including prenatal and delivery services

    c. Dentists

    d. Psychologists (master's level and above), and

    e. Other independent behavioral health professionals who contract directly with the Contractor.

2. The Contractor must ensure:

    a. The credentialing and re-credentialing processes do not discriminate against:

        (1) A health care professional, solely on the basis of license or certification, or

        (2) A health care professional who serves high-risk populations or who specializes in the treatment of costly conditions.

b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.

3. If the Contractor delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this chapter, it must retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of Policy 910 of this Chapter regarding delegation. The QM/PI committee or other peer review body is responsible for over-site regarding delegated credentialing or re-credentialing decisions.

4. Accreditation of the Contractor, specific to its line of business serving AHCCCS members, by the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will demonstrate that credentialing and re-credentialing requirements have been met.

5. If the Contractor is not accredited as described above (4) at a minimum, the standards outlined in this Chapter must be demonstrated through the Contractor policies and procedures. Compliance will be assessed based on the Contractor policies and standards in effect at the time of the credentialing/re-credentialing decision.

6. Written policies must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policies and procedures must be reviewed and approved by the Contractor's executive management, and

   a. Reflect the direct responsibility of the Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee

   b. Indicate the utilization of participating providers in making credentialing decisions, and

   c. Describe the methodology to be used by Contractor staff and the Contractor Medical Director to provide documentation that each credentialing or re-credentialing file was completed and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation.

7. Contractors must maintain an individual credentialing/re-credentialing file for each credentialed provider. Each file must include:

    a. The initial credentialing and all subsequent re-credentialing applications

    b. Information gained through credentialing and re-credentialing queries, and

    c. Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and re-credentialing standards.

Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of physicians and other licensed health care providers must include:

1. A written application to be completed, signed and dated by the provider that attests to the following elements:

    a. Reasons for any inability to perform the essential functions of the position, with or without accommodation

    b. Lack of present illegal drug use

    c. History of loss of license and/or felony convictions

    d. History of loss or limitation of privileges or disciplinary action

    e. Current malpractice insurance coverage, and

    f. Attestation by the applicant of the correctness and completeness of the application.

2. Minimum five year work history

3. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification

4. Verification from primary sources of:

   a. Licensure or certification

   b. Board certification, if applicable, or highest level of credentials attained

   c. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training, if the Contractor lists physician schooling information in member materials or on their web site

   d. National Provider Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:

      (1) Minimum five year history of professional liability claims resulting in a judgment or settlement, and

      (2) Disciplinary status with regulatory board or agency, and

      (3) Medicare/Medicaid sanctions.

5. Behavioral health providers may request a copy of their transcript or proof of education from their educational institution and deliver it themselves in a sealed envelope.

6. Initial site visits for all primary care, OB/GYN and high volume behavioral health care providers.

Temporary/Provisional Credentialing

Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban.

The Contractor must follow the "Initial Credentialing" guidelines 1 through 5 when granting temporary or provisional credentialing. The Contractor shall have 14 days from receipt of a complete application, accompanied by the minimum documents identified above, within which to render a decision regarding temporary or provisional credentialing.

The Contractor must follow the "Initial Credentialing" guidelines 1 through 6 to complete the credentialing process following the granting of temporary or provisional credentials.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation

2. Lack of present illegal drug use

3. History of loss of license and/or felony convictions

4. History of loss or limitation of privileges or disciplinary action

5. Current malpractice insurance coverage, and

6. Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following information:

1. Work history for past five years, and

2. Current DEA or CDS certificate.

The Contractor must conduct primary verification of the following:

1. Licensure or certification

2. Board certification, if applicable, or the highest level of credential attained, and

3. National Provider Data Bank (NPDB) query, or, in lieu of the NPDB query, all of the following:

    a. Minimum five year history of professional liability claims resulting in a judgment or settlement, and

    b. Disciplinary status with regulatory board or agency, and

    c. Medicare/Medicaid sanctions.

The Contractor Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section, should be completed.

Re-credentialing Individual Providers

At a minimum, the re-credentialing policies for physicians and other licensed health care providers must identify procedures that address the re-credentialing process and include requirements for:

1. Re-credentialing at least every three years

2. An update of information obtained during the initial credentialing for sections (1) (except 1c), (3) and (4) (4 b) only requires update if provider is board certified), and

3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:

    a. Medicare/Medicaid sanctions

b. State sanctions or limitations on licensure

c. Member concerns which include grievances (complaints) and appeals information, and

d. Contractor Quality issues.

Credentialing Organizational Providers

For organizational providers included in its network (at a minimum including hospitals, home health agencies, nursing facilities, behavioral health facilities and free-standing surgi-centers):

1. Each Contractor must validate, and re-validate at least every three years, that the organizational provider:

   a. Is licensed to operate in the State, and is in compliance with any other applicable State or Federal requirements, and

   b. Is reviewed and approved by an appropriate accrediting body or, if not accredited, Centers for Medicare and Medicaid Services (CMS) certification or State licensure review may substitute for accreditation. In this case, the Contractor must verify a review was conducted and compliance was achieved by obtaining a copy of the report.

2. ALTCS Contractors, in addition, must review and monitor additional organizational providers in accordance with their contract.

Notification Requirement (Limited to Providers)

The Contractor must have procedures for reporting to appropriate authorities (AHCCCS, the provider's regulatory board or agency, Office of the Attorney General, etc.) any known serious issues and/or quality deficiencies that could result in a provider's suspension or termination from the Contractor's network. If the issue is determined to have criminal implications, a law enforcement agency should also be notified.

1. The Contractor must maintain documentation of implementation of the procedure, as appropriate

2. The Contractor must have an appeal process for instances in which the Contractor chooses to alter the provider's contract based on issues of quality of care and/or service, and

3. The Contractor must inform the provider of the appeal process.

ADES/CMDP PCP Credentialing and Re-credentialing Requirements

In lieu of the credentialing requirements identified in this Chapter of the AMPM, AHCCCS will require the Arizona Department of Economic Security/Comprehensive Medical and Dental program (ADES/CMDP) to establish and enforce the following preferred provider network credentialing requirements:

1. All providers must be AHCCCS-registered

2. Providers must be credentialed by another AHCCCS Contractor. CMDP will be responsible for developing the mechanism that verifies credentialing with the other Contractors.

3. For PCPs who are not credentialed by another AHCCCS Contractor, and who are utilized, or expected to be utilized, more than 25 times in a contract year, CMDP must require all of the following:

    a. Proof that provider is currently credentialed with a NCQA accredited commercial plan

    b. An application and signed attestation statement in compliance with NCQA standards, and

    c. A curriculum vitae with a minimum five-year work history.

4. If the PCP is not credentialed by a NCQA accredited commercial health plan, CMDP must require all of the following:

   a. An application and signed attestation statement in compliance with NCQA standards

   b. A curriculum vitae with a minimum five-year work history.

   c. A verification of valid licensure

   d. A current DEA or CDS certificate, and

   e. A malpractice insurance face sheet.

960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

1. Each Contractor must develop and implement policies and procedures for reviewing, evaluating and resolving issues raised by enrolled members and contracted providers.

   [**NOTE**: References to a member in these standards also include reference to a member's guardian and/or representative.]

2. As a part of the Contractor's process for reviewing and evaluating member and provider issues, there must be written policies and procedures regarding the receipt, initial and ongoing processing of these matters that include:

   a. Documenting each issue raised, when and from whom it was received, and the projected time frame for resolution

   b. Prompt determination of whether the issue is to be resolved through the Contractor's established:

      (1) Quality management program

      (2) Grievance and appeals process

      (3) Process for making initial determinations on coverage and payment issues, or

      (4) Process for resolution of disputed initial determinations.

   c. Acknowledging receipt of the issue and explaining to the member or provider the process to be followed in resolving his or her issue through written correspondence

   d. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue

   e. Ensuring confidentiality of all member information

   f. Informing the member or provider of all applicable mechanisms for resolving the issue external to the Contractor processes, and

g. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance and appeal, including but not limited to:

(1) Corrective action plan(s) or action(s) taken to resolve the concern

(2) In-service attendance and notes

(3) New policies and/or procedures, and

(4) Follow-up with the member that includes, but is not limited to:

i. Assistance as needed to ensure that the immediate health care needs are met, and

ii. Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns.

(Refer to 9 A.A.C. 34 and the AHCCCS contract for information regarding requirements for the grievance system for members and providers.)

3. Contractors must develop and implement policies and procedures that address:

a. Assessment of the level of severity of the quality of care issue

b. Assurance that action is taken when needed by:

(1) Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring

(2) Determining, implementing and documenting appropriate interventions

(3) Monitoring and documenting the success of the interventions

(4) Incorporating interventions into the organization's QM program if successful, or

(5) Assigning new interventions/approaches when necessary

c. Referring the issue to the Contractor peer review committee when appropriate

d. Referring/reporting the issue to appropriate regulatory agency, Child or Adult Protective Services and AHCCCS for further research/review or action

e. Notifying the appropriate regulatory/licensing board or agency and AHCCCS when a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of quality of care issues, and

f. Documenting the criteria and process for closure of the review.

4. Contractors must also develop and implement a system to document, track and evaluate complaints and allegations received from members and providers, inclusive of quality of care issues.

   a. The data from this system must be analyzed and evaluated to determine any trends related to the quality of care in the Contractor's service delivery system or provider network.

   b. Quality tracking and trending information must be submitted to AHCCCS/DHCM/CQM in quarterly reports, and must include the following reporting elements:

      - Types and numbers/percentages of substantiated quality of care issues
      - Interventions implemented to resolve and prevent similar incidences, and
      - Resolution status of "substantiated", "non-substantiated" and "unable to substantiate" quality of care issues.

      If significant negative trends are noted, the Contractor may consider making it the topic for one of its performance improvement projects or other performance improvement activities to improve the issue resolution process itself, and to make improvements that address other system issues raised in the resolution process.

5. Contractors must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse and grievances. Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, HIPAA and 42 CFR 431.300 *et seq*.

6. Information related to coverage and payment issues must be maintained for at least five years following final resolution of the issue, and must be made available to the member, provider and/or AHCCCS authorized staff upon request.

970 PERFORMANCE MEASURES

1. AHCCCS measures the quality of care provided to members. Examples of areas that may be measured include maternal and child health services, wellness and screening services, disease management processes and non-clinical areas such as provider turnover, interpreter services, and cultural competency.

    a. The QM/PI Program must report the performance of the Contractor using standard Performance Measures established or adopted by AHCCCS.

    b. The Contractor must:

        (1) Achieve at least the Minimum Performance Standards established by AHCCCS

        (2) Show demonstrable improvement, sustained over time, toward meeting goals for performance improvement established by AHCCCS

        (3) Develop a corrective action plan, to bring the performance up to at least the minimum level established by AHCCCS. The action plan must be approved by AHCCCS prior to implementation, and

        (4) Comply with national performance measures and levels that may be identified and developed by the Centers for Medicare and Medicaid Services in consultation with AHCCCS and/or other relevant stakeholders.

Refer to the AHCCCS contract for standards related to each AHCCCS required Performance Measure.

980 PERFORMANCE IMPROVEMENT PROJECTS (PIPS) – SELECTION AND ASSESSMENT

1. Performance Improvement Projects

   Each Contractor must conduct PIPs, as described in this policy, to assess the quality and appropriateness of its service provision and to improve performance. If approved by AHCCCS, Contractors may satisfy these requirements by working with one another and/or AHCCCS on collaborative projects.

   a. A PIP is an initiative by the Contractor to:

      (1) Measure performance in:

         (a) One or more of the focus topics described in this policy

         (b) An area(s) of special interest to the Contractor that has been approved by AHCCCS, or

         (c) A topic that has been mandated by AHCCCS.

      (2) Undertake system interventions to improve quality, and

      (3) Evaluate the effectiveness of those interventions.

   b. PIPs must be designed, through ongoing measurement and intervention, to achieve:

      (1) Demonstrable improvement, sustained over time, in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction

      (2) Correction of significant systemic problems that come to the attention of the Contractor through:

         (a) Internal surveillance and service delivery monitoring

         (b) Credentialing/re-credentialing

         (c) Tracking and trending of complaints/allegations

(d) Member and/or provider satisfaction surveys, or

(e) Other mechanisms.

2. Selection of clinical and non-clinical focus topics for PIPs.

a. Project topics, and the performance measures used to assess each project, can be chosen either by the Contractor, or

b. AHCCCS may require a Contractor to conduct particular projects that are specific to the organization or that relate to statewide topics and/or involve AHCCCS or the Centers for Medicare and Medicaid Services (CMS) performance measures.

c. Clinical focus topics may include the following:

(1) Primary, secondary, and/or tertiary prevention of acute conditions

(2) Primary, secondary, and/or tertiary prevention of chronic conditions

(3) Care of acute conditions

(4) Care of chronic conditions

(5) High-risk services, and

(6) Continuity and coordination of care.

d. Non-clinical focus topics may include the following:

(1) Availability, accessibility and adequacy of the Contractor's service delivery system

(2) Cultural competency of services

(3) Interpersonal aspects of care (i.e., quality of provider/member encounters), and

(4) Appeals, grievances, and other complaints.

e. Annually, Contractors are required to select a specific topic or topics to be addressed by a PIP unless otherwise notified by AHCCCS. In addition, AHCCCS retains the option of mandating a PIP topic for performance improvement by Contractors if an area of need is identified. Contractor PIPs must document the methodology and criteria used in the selection process, including:

(1) The purpose of the project

(2) The reason for choosing the topic and why it is important to the Contractor

(3) What aspect of the Contractor's members' needs, care or services the PIP will address, and

(4) The data methodology used to select the project.

f. The Contractor must identify PIP topics through continuous data collection and analysis of comprehensive aspects of its health care delivery system and member services.

g. Topics should be systematically selected and prioritized to achieve the greatest practical benefit for enrolled members.

h. Selection of topics must take into account:

(1) The prevalence of a condition among, or the need for a specific service by, the Contractor's members

(2) The member demographic characteristics and health risks

(3) The interest of members, providers, AHCCCS and/or CMS, in the aspect of care or services to be addressed, and

(4) Member input, whenever possible, in the selection of topics for a Contractor PIP, and formulation of project goals.

3. Study Questions

   a. The question(s) the study is designed to answer must be stated as clearly and concisely as possible in order to ensure a good understanding of the question(s) without ambiguity.

   b. Limiting the number of question(s) will make the project manageable and meaningful, and

   c. Relevant clinical literature and other supporting information are good potential sources in developing study questions.

4. Performance measures

   a. Assessment of the organization's performance for each topic selected for a PIP must be measured using one or more performance measures.

   b. Performance measures must be objective, clearly defined, and based on current clinical knowledge or health services research. When HEDIS® measures or other measures that are generally used within the medical community or the managed care industry exist, and are applicable to the topic, they should be utilized. This allows for comparison of the organization's performance to that of similar organizations or to local, state, or national benchmarks.

   c. Performance measures must measure outcome and be clearly defined. The descriptions of the performance measures must include the criteria for determining how the measure will be met.

   d. Performance measures selected for a clinical focus topic must include a measure of change in health status, functional status or process of care proxies for these outcomes. Performance measures may also include measures of the member's experience of, and satisfaction with, the health care provided to him/her.

   e. Performance measures of processes may be used in place of performance measures for outcome only when those processes have been established as significantly related to outcomes through published studies or a consensus of relevant providers.

5. Population selected for the PIP

   a. The population to be studied in the PIP must be clearly defined and the methodology must indicate if the entire population or a representative sample will be used

   b. If a sample is used:

      (1) The methodology must define the "sample frame" or subgroup of the population that will be included

      (2) The criteria for inclusion of the sample frame must be clearly stated

      (3) A clear description of how the sample frame is to be obtained must be incorporated into the plan

      (4) The sampling technique must include any stratification, the confidence level and interval, and over-sampling, and

      (5) The sampling plan must ensure a sufficient number of enrolled members are included in the sample.

6. Data collection methodology

   a. Assessment of Contractor's performance on the selected measures must be based on systematic, ongoing collection and analysis of accurate, valid and reliable data.

      (1) The source(s) of data to be used must be clearly identified and must be an appropriate data source(s) to answer PIP study questions. Wherever possible, primary source data that is not more than two years old should be used unless otherwise approved in advance.

      (2) All data tools to be used must provide for consistent and accurate data collection, and must be identified in the PIP proposal. A description of the process that is to be used to ensure the data being collected is accurate must also be included, and

(3) Qualified personnel must be used for data collection and analysis and the PIP must describe how inter-rater reliability will be established if abstractors are used.

b. The Contractor must:

(1) Establish a baseline measure of its performance for each measure

(2) Measure changes in performance, and

(3) Continue measurement for an established period of time, as specified in the PIP proposal and approved by AHCCCS.

c. The sampling methodology for assessment of the Contractor's performance, when sampling methodology is used, must ensure that the data collected validly reflects:

(1) The performance of all providers who serve AHCCCS members and whose activities are the subject of the measure, and

(2) The care given to the entire population to which the measure is relevant (including populations with special health care needs).

7. PIP timeframes

a. The first review year of a PIP begins on a date, established by AHCCCS, after the Contractor submits its proposal for review and approval, and will correspond with contract years.

b. Each Contractor will have a two-year period during which data is being collected and analyzed. Therefore, projects will not be required to achieve demonstrable improvement during this time period (assuming a three-year project cycle).

c. By the end of the first review year, the Contractor must initiate another project that has been approved by AHCCCS.

(1) The PIP may be selected by the Contractor to address a clinical or non-clinical focus topic determined by the Contractor to be of interest or impact to its organization.

(2) AHCCCS may require a Contractor to conduct a PIP as a focused improvement project, if determined necessary, based on the Contractor's performance, or

(3) AHCCCS may require all Contractors to conduct a PIP as a single statewide project, or as an additional (second) PIP.

c. By the end of the second review year, each Contractor must initiate another project addressing a topic approved by AHCCCS. Selection criteria stated in 2.c through 2.h of this policy also apply to the second review year, and

d. By the end of the third review year of the PIP (after the two-year data gathering and analysis period has been completed) and for each subsequent review year, at least one of the Contractor's PIPs should have achieved demonstrable improvement.

8. Measurement of Demonstrable Improvement

a. The Contractor must initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance measures being measured. Improvement must be evidenced in repeat measurements of the performance measures specified for each PIP undertaken by the Contractor. Sustained improvement is achieved when:

(1) Contractor maintains or increases the improvements in performance for at least one year after the improvement in performance is first achieved, and

(2) Contractor documents continued measurement of performance measures, to indicate maintenance, for at least one year after the PIP achieves substantial improvement, as specified by AHCCCS.

b. When a PIP measures performance related to performance measures by collecting data on all units of analysis in the population to be studied, significant improvement should be demonstrated by achieving:

(1) A benchmark level of performance defined in advance by AHCCCS for statewide projects, or

(2) In the case of a project developed by the Contractor for its own system, a benchmark level of performance that is defined in advance and approved by AHCCCS prior to initiation.

c. The Contractor must strive to meet, maintain and/or exceed the benchmark(s) proposed for the PIP. During any review year, a project will be considered to have achieved demonstrable improvement when improvement has met the established, approved benchmark.

d. If the review period of a project is conducted over more than one year:

(1) The project will be considered as achieving demonstrable improvement in each year for which it meets the requirements specified in this section, or

(2) The project may be considered as achieving demonstrable improvement in each year for which it achieves improvement that does not meet the requirements specified in this section, but that constitutes an intermediate target specified in a project work-plan approved by AHCCCS.

e. When a project measures performance related to performance measures by collecting data on a subset (sample) of the units of analysis for the population to be studied, significant improvement should be demonstrated by achieving the approved benchmarks. The sample must be sufficiently large to detect the targeted amount of improvement.

f. The samples used for the baseline and repeat measurements of the performance measures must be chosen using the same sampling frame and methodology.

g. The Contractor must demonstrate how the improvement can be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, not another unrelated reason).

9. PIP Reporting Requirements.

Prior to beginning a PIP, the Contractor must submit its proposal, including an implementation plan, to AHCCCS for review and approval. It should include at least the following components:

a. PIP title

b. Implementation date

c. Reason and methodology for selecting the topic

d. Study questions that are clear, concise and understandable

e. Proposed measures and criteria for determining if performance meets the measure, including national or regional benchmarks if available, or project goals if different than available benchmarks

f. Sample selection and size

g. Data collection methodology, data source and proposed methods for data analysis, and

h. Initial evaluation, improvement and intervention plan, and reevaluation criteria.

(1) After completing the first year of the PIP, each Contractor must submit a report that includes:

(a) An evaluation of baseline data

(b) Proposed interventions that will be implemented during the second review year to improve the performance measure

(c) Proposed strategies to implement interventions and measure performance after the interventions are in place, and

(d) Projected results.

(2) During the third year, re-measurement of performance is conducted to determine demonstrable improvement, as proposed in the Contractor's initial proposal.

(a) If demonstrable improvement has been achieved, a report is submitted which details the PIP methodologies, interventions and findings, and

(b) If the PIP interventions did not result in demonstrable improvement, these findings should also be reported along with proposed actions to revise, replace and/or initiate new interventions to improve the performance measure.

(3) During the fourth year, re-measurement of performance is conducted to determine if sustained improvement has been achieved.

(a) If sustained improvement has been achieved, a final report is submitted which details the PIP methodologies, interventions and findings, and

(b) If sustained improvement has not been achieved, these findings should also be reported along with proposed actions to revise, replace and/or initiate new interventions to improve and sustain the performance measure.

990 REPORTING REQUIREMENTS

Contractors must submit the following data reports as indicated.

REPORT	DUE DATE	REPORTS DIRECTED TO
Performance Improvement Project Proposal(s)	Annually by December 15	Division of Health Care Management/Clinical Quality Management Unit (DHCM/CQM)
Quality Management/Performance Improvement Plan	Annually by December 15	DHCM/CQM
Quality Management/Performance Improvement Program Evaluation	Annually by December 15	DHCM/CQM
Performance Improvement Project Baseline Report	By December 15 following initial year of study	DHCM/CQM
Performance Improvement Project Final Evaluation Report (including any new QM/PI activities implemented as a result of the project)	Annually by March 31	DHCM/CQM
Corrective Action Plan for deficiencies noted in: 1. An Operations Field Review 2. A Focused Review 3. QM/PI Plan 4. Performance related to Quality Measures	30 days after receipt of notice to submit a Corrective Action Plan (CAP) unless otherwise stated.	DHCM/CQM
Quarterly QM Reports	45 days after end of quarter	DHCM/CQM

NOTE: The Arizona Department of Health Services/Division of Behavioral Health (ADHS/DBHS) must:

- Refer to their AHCCCS Contract for due dates, and

- Submit all reports to AHCCCS DHCM/Behavioral Health Unit.

If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the AHCCCS/DHCM/Clinical Quality Management Unit, or, for ADHS/DBHS, a request to the DHCM/Behavioral Health Unit

Refer to Chapter 400 for reporting requirements related to maternity services and/or EPSDT.

Refer to Chapter 1000 for reporting requirements related to Utilization Management.